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HIV study details risk behaviors

A new survey of more than 500 HIV-infected persons in Orange County shows the need for prevention programs to target questionable beliefs and high-risk sexual behaviors.

The survey was conducted in June and July 2000 among HIV-positive individuals receiving services at nine Ryan White CARE Act providers in Orange County. The survey showed the majority of respondents have been sexually active in the past six months and that 61% of those reporting vaginal and/or anal sex followed safer sexual practices. However, one in three respondents (36%) believe that because of new HIV treatments, HIV is no longer a life-threatening disease.

The study also found that one in four persons surveyed had multiple sexual partners in the past six months and a like percentage had engaged in unprotected sex during the same period. Of persons who reported participating in surveyed sexual behavior at least once in the past six months, 43% said they rarely or never discussed HIV before having sex, and almost one-quarter said they did not know the HIV status of one or more of their sexual partners. These serious risk factors for the transmission of HIV demonstrate the need for prevention services.

"HIV treatments have clearly improved the health of many HIV-positive persons in Orange County," said Dr. Mark Horton, County Health Officer and Deputy Agency Director/Public Health Services. "The open question was whether their beliefs about the disease were also being affected by the treatments. Now, with this new study, we know. The next step is to provide prevention programs that accurately describe the impact of the new treatments on HIV and help persons who are HIV positive practice safe sex."

Almost two-thirds of the respondents to the survey were between 30-44 years of age and about eight in ten were males. Latinos were the largest ethnic group, constituting about half of the respondents. About 57% of respondents identified themselves as gay or lesbian and over 82% of the those participating in the survey reported being infected with HIV through sexual contact.

There is concern about other findings of the study included in the report. For example, one in two respondents said that people in general are now less worried about getting HIV. Fourteen percent of the respondents said that HIV-positive persons who use the new treatments are less likely to transmit HIV during sex. Seven percent of the respondents said they were now more willing to have sex without a condom because of the new treatments.

HIV-infected individuals traditionally have not been a focus of prevention efforts for reasons including the belief that relatively few engaged in sex after learning they were infected. Also, advocates for persons with HIV have long argued that the primary needs of persons with the disease were medical and social services to support the final stages of life. However, new treatments for HIV have resulted in many persons with HIV living longer and feeling better. "The findings in this study leave no doubt that the absence of prevention efforts for HIV-positive individuals is a big gap in the battle against HIV," says Dr. Horton.

Researchers also found that various subgroups of the respondents appear to differ in their beliefs about HIV treatments. For example, over 54% of older respondents (age 45+) strongly disagreed with the statement that HIV is

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Table 1. HIV Beliefs

	Strongly Agree %	Somewhat Agree %	Somewhat Disagree %	Strongly Disagree %	Don't Know %
People are less worried now about getting HIV	13.4	38.9	21.5	18.0	8.1
HIV is no longer a life-threatening disease because of new treatments	11.4	24.2	19.1	41.7	3.7
HIV transmission is less likely when new treatments are used	7.8	6.5	13.1	64.1	8.4
I am more willing to have sex without a condom because of new treatments	4.0	3.0	8.5	81.2	3.4

Note. The number of respondents answering these questions ranged from 505 to 510.

Twenty years of the HIV/AIDS epidemic

Twenty years ago on June 5, 1981, the Centers for Disease Control published its first report of five cases of *Pneumocystis carinii* infection in previously healthy men in Los Angeles. And so the HIV/AIDS epidemic was upon us.

Much, of course, has happened in the intervening years. Risk factors have been identified, and preventive strategies, including counseling and testing programs, have been developed and implemented. Perinatal transmission has been significantly reduced. Increasingly effective treatments have been developed and made available along with more comprehensive and holistic management strategies. The pattern of the epidemic in our communities has changed: more heterosexual transmission; more women, blacks, Latinos and intravenous drug abusers affected. The epidemic has become globalized: virtually the entire continent of Africa and numerous other nations have been afflicted with astronomical infection rates.

Here in the United States, while efforts to develop an effective vaccine have failed to date, other prevention and treatment strategies have been modestly effective: deaths from and reports of new cases of AIDS have diminished somewhat since the early to mid nineties, while the number of individuals living with HIV continues to climb.

What are the principal challenges in dealing with the HIV/AIDS epidemic as it enters its third decade? First, we must have better surveillance tools to better monitor the epidemic and assess the effectiveness of our prevention and treatment strategies in a timely manner. The implementation of "no-name" mandatory reporting as planned here in California will take us a step in the right direction. Second, we must continue to realign our prevention strategies with our knowledge of emerging patterns of the epidemic. Specifically, we need to target populations at increasing risk including women, blacks, Latinos and intravenous drug abusers. A recent report documenting a reversion to unsafe sex practices among infected men having sex with men in response to optimism about the effectiveness of drug treatment will require us to refocus on this population. Third, we need to continue an aggressive search for an effective vaccine and increasingly effective treatments while working toward universal access to current prevention and treatment programs. As treatments become more effective and the number of individuals living with HIV continues to rise we need to increasingly adopt a chronic disease model to ensure treatments are delivered in a context of comprehensive and continuous care.

The response of the Orange County community to the epidemic has been remarkable. The coordinated efforts of the health care community, various community providers, and the Health Care Agency working through the HIV Planning Council have resulted in a highly effective network of prevention and treatment services. While the challenges continue to be great, I feel confident that this community will continue to be able to effectively meet those challenges.

Mark Horton, MD, MSPH, is Deputy Agency Director and Public Health Officer of the County of Orange Health Care Agency

HIV Study *(Continued from Page 1)*

no longer a life-threatening disease, whereas only 23.5% of the respondents between 18-29 years of age did so.

Respondent characteristics were often associated with the practice of unprotected sex. For example, respondents who reported a low viral load were significantly more likely to disagree with the statement "*I am more willing to have sex without a condom because of new treatments*." Respondents under 45 years of age were more likely to report unprotected sex, which may reflect the fact that younger persons tend to have sex more often than do older persons. It may also be that older respondents are more responsive to prevention messages.

The study also found that acculturation was associated with beliefs about the new HIV treatments. Latinos who completed the questionnaire in Spanish were more likely to agree with the statement *HIV is no longer a life-threatening disease because of new HIV treatments* than were Latinos who completed the questionnaire in English. Similarly, Latinos who completed the questionnaire in Spanish were more likely to agree with the statement that *HIV-positive persons are less likely to transmit HIV during sex if they use the new treatments* than were Latinos who completed the questionnaire in English. These findings point to the need for culturally sensitive prevention and education programs for HIV-positive persons.

Acculturation was also found to be adversely associated with reports of unprotected sex. Latinos who completed the questionnaire in English were significantly more likely to report unprotected sex than were Latinos who completed the questionnaire in Spanish. Reports of unprotected sex from Whites/Others were similar to those of Latinos who completed the questionnaire in English.

While information from the survey will be extremely useful in planning future prevention efforts, the limitations of the survey were also acknowledged. Because the study was conducted at Ryan White CARE Act providers, clients may differ from HIV-positive individuals who are not clients of such providers. Behavior related to sensitive topics such as those considered in this survey tend to be underreported. Beliefs about HIV treatments are also likely to change as advances occur in the treatment of HIV.

The study was recommended by the Prevention Planning Committee of the Board of Supervisors-appointed HIV Planning Council. It was commissioned by the Orange County Health Care Agency, Office of HIV Programs, funded by the California State Office of AIDS, and conducted by the Public Statistics Institute of Irvine.

Data from the study is important in that it provides information specific to HIV-positive persons in Orange County. Researchers found that as of 1999, only 14 studies had been published on the sexual behavior of HIV positive persons and the majority of these were conducted before the advent of new HIV treatments. Only a small number of studies have examined whether persons who are now less concerned about HIV are more likely to have unprotected sex. These studies produced inconsistent findings and most of the research has focused on people who are HIV-negative.

The complete survey, entitled "*Sexual Risk Behavior and HIV Treatment Optimism - HIV Positive Persons at Ryan White CARE Act Providers in Orange County*" can be accessed on the Health Care Agency website from the on-line publications page located at:

http://www.oc.ca.gov/hca/publicat.htm

Shortage of Td vaccine brings use recommendations

The national shortage of Tetanus/Diphtheria (Td) "Adult" type vaccine has affected all practitioners. Local Health Officers were briefed by the State Department of Health Services, Immunization Branch in June. The following information chronicles the events that have led to this shortage and details recommendations for the limited use of this scarce vaccine that will be in effect until 2002, when it is anticipated that supplies will become more readily available.

Background

A temporary shortage of Td vaccine developed in mid-2000, when there were production issues involving the two firms marketing the vaccine in the U.S. In February 2001, Wyeth Lederle permanently discontinued all Td production and sales in the U.S. The remaining firm, Aventis Pasteur, announced that it would work to expand its production of Td vaccine but that it would be early-2002 before production could fully match demand. Concurrently, there is an extreme shortage of the less-commonly-used "single antigen" tetanus toxoid (TT).

Guidelines

In May 2001, the Centers for Disease Control and Prevention (CDC) issued revised and more restrictive guidelines for prioritizing usage of available Td vaccine for the duration of the shortage (MMWR 2001 [May 25]; 50:418 and 427).

1. Discontinue all routine Td boosters in adolescents and adults. Maintain a list of patients whose boosters are deferred for recall to receive the booster when the Td vaccine shortage ends.
2. Confine Td vaccine use to the following:

a) Persons traveling to countries where diphtheria risk is high (many developing countries and countries of the former Soviet Union);

b) Persons requiring tetanus prophylaxis for wound management;

c) Persons who have received less than three (3) lifetime doses of any vaccine containing tetanus and diphtheria toxoids; and

d) Pregnant women who have not received Td vaccine during the preceding 10 years, with *use limited to those who plan to or are otherwise likely to deliver their babies out of hospitals*.

Immigration and Naturalization Service (INS)

CDC's Division of Quarantine (DQ) has announced an automatic waiver of the Td vaccination requirements for immigrants, effective through September 30, 2001.

- INS Supplemental Form to I-693 (Adjustment of Status Applicant's Documentation of Immunization) does not have an "unavailable in country" box for vaccines. Therefore, it is necessary to write "not available" on the form.
- INS offices may not be aware of the waiver. Civil surgeons who encounter problems with local offices should contact DQ by FAX at (404) 639-2599, Attention: Visa Medical Activity.
- At the end of September, the situation will be reevaluated and if the Td shortage continues, the waiver period could be extended.

Vaccine Availability

In June 2001, Aventis Pasteur informed the USPHS Advisory Committee on Immunization Practices (ACIP) that it was making a policy change, effective immediately, for "shipping Td vaccine only to public health clinics and urgent care facilities (such as emergency rooms and burn units) so that adequate supplies are available to meet priority needs, as defined by the CDC." Institutions can place orders for the Td vaccine *for priority indications only* by calling Aventis Pasteur at 1-800-822-2463 (1-800-VACCINE).

Public Health

The limited supply of Td vaccine that is available to Public Health is focused on preventive health services, where vaccine is provided only to: (1) persons traveling to countries where diphtheria risk is high; and (2) persons who received less than three (3) lifetime doses of any vaccine containing tetanus and diphtheria toxoids. *Persons requiring tetanus prophylaxis for wound management should be served at the location where their wound care is provided.*

Questions or concerns about Td vaccine, any other vaccine, or immunization practices should be directed to the Immunization Assistance Project at (714) 834-8560, or to Gerald Wagner, M.D., Public Health Medical Consultant, at (714) 834-8411.

HIPAA and Public Health

The Health Insurance Portability and Accountability Act (HIPAA) was passed by Congress in 1996 and resulted in promulgation of regulations regarding the privacy of medical records. These regulations took effect on April 14, 2001; however, there is a 2-year period (3 years for some providers) for coming into compliance. More information on HIPAA is available at:

http://aspe.os.dhhs.gov/admnsimp/

It is crucial for physicians to understand that there is a **public health exception** in HIPAA to the requirement for patient consent in sharing protected information. That exception is spelled out in Section 164.512(b)(1)(i) of the regulations, which reads as follows.

§ 164.512 Uses and disclosures for which consent, an authorization, or opportunity to agree or object is not required.

(b) ***Standard: uses and disclosures for public health activities.***

(1) ***Permitted disclosures.*** A covered entity may disclose protected health information for the public health activities and purposes described in this paragraph to:

(i) A public health authority that is authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, including, but not limited to, the reporting of disease, injury, vital events such as birth or death, and the conduct of public health surveillance, public health investigations, and public health interventions; or, at the direction of a public health authority, to an official of a foreign government agency that is acting in collaboration with a public health authority

In addition, HIPAA does not preempt mandated reporting under state law.

Many physicians are not aware that under current law, **no patient consent is required** for reporting to Public Health, and all required or requested information can be provided without patient consent. It is always best to inform your patient when you do report to Public Health so that they will not be alarmed if we contact them.

Information on reporting and a form that can be used to report are available at:

http://www.oc.ca.gov/hca/public/cdcerdi.htm

or by calling the Communicable Disease Control and Epidemiology program at (714) 834-8180.

Assistance in meeting the HIPAA requirements is available from the Department of Health and Human Services Office for Civil Rights toll free at: (866) 627-7748. Information, including guidance documents to clarify the regulations, is also available on their web site:

http://www.hhs.gov/ocr/hipaa/.

ORANGE COUNTY REPORTED CASES OF SPECIFIED NOTIFIABLE DISEASES

First and Second Quarters (Weeks 1-26)
Number of Cases by Year of Report (YTD)

DISEASE	2001	2000	1999	1998
AIDS	157	150	137	154
AMEBIASIS	17	13	10	18
CAMPYLOBACTERIOSIS	133	167	113	136
CHLAMYDIA	2,631	2,591	2,734	1,924
CRYPTOSPORIDIOSIS	4	1	3	6
E-COLI O157:H7	1	3	2	1
FOOD POISONING OUTBREAKS	17	6	10	2
GIARDIASIS	85	113	111	131
GONOCOCCAL INFECTION	294	315	279	317
H-FLU, INVASIVE DISEASE	2	3	4	4
HANSEN'S DISEASE, LEPROSY	0	1	1	3
HEPATITIS A (acute)	80	138	115	127
HEPATITIS B (acute)	22	33	24	41
HEPATITIS B (chronic)	785	828	822	818
HEPATITIS C (acute)	6	1	8	4
HEPATITIS C (chronic)	1,340	1,319	1,129	771
HEPATITIS OTHER/UNSPECIFIED	6	17	12	12
KAWASAKI DISEASE	7	10	10	9
LISTERIOSIS	8	5	5	4
MALARIA	5	7	4	9
MEASLES (RUBEOLA)	4	0	4	1
MENINGITIS, TOTAL	96	136	111	236
ASEPTIC MENINGITIS	77	97	78	197
MENINGOCOCCAL INFECTIONS	11	15	11	21
MUMPS	2	3	2	5
NON-GONOCOCCAL URETHRITIS	303	368	268	373
PERTUSSIS	5	12	21	3
PELVIC INFLAMMATORY DISEASE	25	32	11	37
RUBELLA	0	1	0	0
SALMONELLOSIS	118	159	117	175
SHIGELLOSIS	47	101	67	57
STREP, INVASIVE GROUP A	20	24	25	45
SYPHILIS, TOTAL	76	125	106	76
PRIMARY	7	3	11	7
SECONDARY	12	10	8	4
EARLY LATENT	13	8	12	5
LATENT	5	4	1	0
LATE LATENT	39	91	71	56
CONGENITAL	0	9	2	4
NEUROLOGICAL	0	0	1	0
TUBERCULOSIS	78	80	101	119
TYPHOID FEVER, CASE	0	0	1	2

County of Orange Health Care Agency

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